FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037515

Facility Name: Montgomery Place

Address: 5550 South Shore Drive (Number) Chicago (City) 60637 (Zip Code)

County: Cook

Telephone Number: (773) 753-4100 **Fax #** (773) 752-0056

IDPA ID Number: 36-3582046001

Date of Initial License for Current Owners: 1/24/92

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 (C) (3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/99 to 6/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed) SEE ACCOUNTANT'S REPORT ATTACHED	(Date)
	(Print Name and Title) Marvin Fox, C.P.A.	
	(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C. 111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015	
	(Telephone) (847) 236-1111	Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	47	Skilled (SNF)	47	17,202	1
2		Skilled Pediatric (SNF/PED)			2
3	46	Intermediate (ICF)	46	16,836	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	34,038	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	0	18	4,243	4,261	8
9	SNF/PED					9
10	ICF	5,321	17,553	1,770	24,644	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,321	17,571	6,013	28,905	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.92%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1/28/92

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 4,195

Medicare Intermediary Wellmark, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/00 Fiscal Year: 6/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	384,518	77,440	22,487	484,445		484,445	(41,629)	442,816			1
2	Food Purchase		505,493		505,493	(24,376)	481,117	(238,030)	243,087			2
3	Housekeeping	144,020	15,092	403	159,515		159,515		159,515			3
4	Laundry	43,353	8,405	207	51,965		51,965	(269)	51,696			4
5	Heat and Other Utilities			265,235	265,235		265,235	(192,566)	72,669			5
6	Maintenance	144,702	24,631	169,560	338,893		338,893	(97,476)	241,417			6
7	Other (specify):*											7
8	**TOTAL General Services**	716,593	631,061	457,892	1,805,546	(24,376)	1,781,170	(569,970)	1,211,200			8
	B. Health Care and Programs											
9	Medical Director			13,701	13,701		13,701		13,701			9
10	Nursing and Medical Records	1,229,809	194,015	21,501	1,445,325		1,445,325	(13,007)	1,432,318			10
10a	Therapy											10a
11	Activities	89,894	132	613	90,639		90,639		90,639			11
12	Social Services	37,954		486	38,440		38,440	(241)	38,199			12
13	Nurse Aide Training											13
14	Program Transportation	15,736	613	3,000	19,349		19,349	(8,442)	10,907			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,373,393	194,760	39,301	1,607,454		1,607,454	(21,690)	1,585,764			16
	C. General Administration											
17	Administrative	59,675		18,838	78,513		78,513	(9,357)	69,156			17
18	Directors Fees											18
19	Professional Services			332,279	332,279		332,279	(181,017)	151,262			19
20	Dues, Fees, Subscriptions & Promotions			92,808	92,808		92,808	(46,377)	46,431			20
21	Clerical & General Office Expenses	151,445	52,556	1,067,471	1,271,472		1,271,472	(874,379)	397,093			21
22	Employee Benefits & Payroll Taxes			390,433	390,433	24,376	414,809	(94,108)	320,701			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,467	10,467		10,467	(5,942)	4,525			24
25	Other Admin. Staff Transportation			58,678	58,678		58,678	(56,691)	1,987			25
26	Insurance-Prop.Liab.Malpractice			69,812	69,812		69,812	(50,685)	19,127			26
27	Other (specify):*											27
28	**TOTAL General Administration**	211,120	52,556	2,040,786	2,304,462	24,376	2,328,838	(1,318,556)	1,010,282			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,301,106	878,377	2,537,979	5,717,462		5,717,462	(1,910,216)	3,807,246			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Montgomery Place **0037515**

COST REPORT RECLASSIFICATIONS

7/1/99

6/30/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	24,376	
2	FOOD		24,376

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number Montgomery Place #0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			941,974	941,974		941,974	(741,876)	200,098			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,650,636	1,650,636		1,650,636	(1,201,294)	449,342			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			53,719	53,719		53,719	(26,684)	27,035			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,646,329	2,646,329		2,646,329	(1,969,854)	676,475			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		232,833	236,344	469,177		469,177		469,177			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,057	51,057		51,057		51,057			42
43	Other (specify):*			1,217,802	1,217,802		1,217,802	(1,217,802)				43
44	**TOTAL Special Cost Centers**		232,833	1,505,203	1,738,036		1,738,036	(1,217,802)	520,234			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,301,106	1,111,210	6,689,511	10,101,827		10,101,827	(5,097,872)	5,003,955			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(58,641)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(6)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(10,582)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(84,832)	21		18
19	Entertainment	(2,093)	21		19
20	Contributions	(550)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(516,416)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,424,752)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (5,097,872)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (5,097,872)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Montgomery Place

ID# 0037515

Report Period Beginning: 7/1/99

Ending: 6/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Resident Relations	(2,374)	21	2
3	Miscellaneous Services Revenue	(5,393)	21	3
4	Personal Care Revenue	(9,172)	10	4
5	Transportation Revenue	(6,648)	14	5
6	Tray Service	5	2	6
7	Vending Revenue	(44)	1	7
8	Undocumented Seminar Expense	(1,475)	24	8
9	Management Fees - Church Home	(18,000)	21	9
10	Alcohol Beverages	(6,000)	2	10
11	Community Outreach Program	(2,815)	21	11
12	Vehicle Rental (out-of-state)	(83)	6	12
13	Prior Year Legal	(2,618)	19	13
14	Duplicated Legal	(2,121)	19	14
15	Unsupported Legal	(26,982)	19	15
16	PPA - Payroll	(3,829)	10	16
17	Travel Expense (out-of-state)	(54,729)	25	17
18	Assets reclassed to Expense	2,876	6	18
19	Capitalized Repairs & Maintenance	(4,810)	6	19
20	INDEPENDENT LIVING EXPENSES:			20
21	Dietary	(41,585)	1	21
22	Food	(173,394)	2	22
23	Program Transportation	(1,794)	14	23
24	Laundry	(269)	4	24
25	Utilities	(192,566)	5	25
26	Maintenance	(95,459)	6	26
27	Social Service	(241)	12	27
28	Administrative	(9,357)	17	28
29	Professional Fees	(149,296)	19	29
30	Dues, Fees, Subscriptions	(45,827)	20	30
31	Clerical & General Office	-242456	21	31
32	Employee Benefits	-94108	22	32
33	Seminar	-4467	24	33
34	Staff Transportation	-1962	25	34
35	Insurance	-50685	26	35
36	Depreciation	-741876	30	36
37	Interest	-1190712	32	37
38	Equipment Rental	-26684	35	38
39	Independent Living / Marketing	-1217802	43	39
40				40
41				41
42				42
43				43
44				44
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88				88
89				89
90	**Total**	(4,424,752)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(41,629)	0	0	0	0	0	0	0	0	0	0	(41,629)	1
2	Food Purchase	(238,030)	0	0	0	0	0	0	0	0	0	0	(238,030)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(269)	0	0	0	0	0	0	0	0	0	0	(269)	4
5	Heat and Other Utilities	(192,566)	0	0	0	0	0	0	0	0	0	0	(192,566)	5
6	Maintenance	(97,476)	0	0	0	0	0	0	0	0	0	0	(97,476)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(569,970)	0	0	0	0	0	0	0	0	0	0	(569,970)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(13,007)	0	0	0	0	0	0	0	0	0	0	(13,007)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(241)	0	0	0	0	0	0	0	0	0	0	(241)	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(8,442)	0	0	0	0	0	0	0	0	0	0	(8,442)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(21,690)	0	0	0	0	0	0	0	0	0	0	(21,690)	16
	C. General Administration													
17	Administrative	(9,357)	0	0	0	0	0	0	0	0	0	0	(9,357)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(181,017)	0	0	0	0	0	0	0	0	0	0	(181,017)	19
20	Fees, Subscriptions & Promotions	(46,377)	0	0	0	0	0	0	0	0	0	0	(46,377)	20
21	Clerical & General Office Expenses	(874,379)	0	0	0	0	0	0	0	0	0	0	(874,379)	21
22	Employee Benefits & Payroll Taxes	(94,108)	0	0	0	0	0	0	0	0	0	0	(94,108)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(5,942)	0	0	0	0	0	0	0	0	0	0	(5,942)	24
25	Other Admin. Staff Transportation	(56,691)	0	0	0	0	0	0	0	0	0	0	(56,691)	25
26	Insurance-Prop.Liab.Malpractice	(50,685)	0	0	0	0	0	0	0	0	0	0	(50,685)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(1,318,556)	0	0	0	0	0	0	0	0	0	0	(1,318,556)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,910,216)	0	0	0	0	0	0	0	0	0	0	(1,910,216)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Montgomery Place # 0037515 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(741,876)	0	0	0	0	0	0	0	0	0	0	(741,876)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,201,294)	0	0	0	0	0	0	0	0	0	0	(1,201,294)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(26,684)	0	0	0	0	0	0	0	0	0	0	(26,684)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,969,854)	0	0	0	0	0	0	0	0	0	0	(1,969,854)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,217,802)	0	0	0	0	0	0	0	0	0	0	(1,217,802)	43
44	**TOTAL Special Cost Centers**	(1,217,802)	0	0	0	0	0	0	0	0	0	0	(1,217,802)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(5,097,872)	0	0	0	0	0	0	0	0	0	0	(5,097,872)	45

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Montgomery Place Independent Living Ctr.
Street Address: 5550 South Shore Drive
City / State / Zip Code: Chicago, IL 60637
Phone Number: (773) 753-4100
Fax Number: (773) 752-0056

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Meals	148,569		$ 99,883	$	86,715	$ 58,299	1
2	2	Food	Meals	148,569		416,481		86,715	243,087	2
3	3	Housekeeping		1		15,495		1	15,495	3
4	4	Laundry	Pounds	327,226		8,612		316,981	8,342	4
5	5	Utilities	Square Feet	234,706		265,235		64,305	72,669	5
6	6	Maintenance	Revenue	8,216,819		192,174		4,135,295	96,716	6
7	9	Medical Director		1		13,701		1	13,701	7
8	10	Nursing / Medical Records		1		202,509		1	202,509	8
9	14	Program Transportation	Revenue	8,216,819		3,613		4,135,295	1,818	9
10	17	Administrative	Revenue	8,216,819		18,838		4,135,295	9,481	10
11	19	Professional Fees	Revenue	8,216,819		300,558		4,135,295	151,262	11
12	20	Dues, Fees, Subscriptions	Revenue	8,216,819		92,258		4,135,295	46,431	12
13	21	Clerical & General Office	Revenue	8,216,819		488,104		4,135,295	245,649	13
14	22	Employee Benefits	Salaries	2,967,762		414,809		2,294,457	320,700	14
15	24	Travel & Seminar	Revenue	8,216,819		8,992		4,135,295	4,525	15
16	25	Staff Transportation	Revenue	8,216,819		3,949		4,135,295	1,987	16
17	26	Insurance	Square Feet	234,706		69,812		64,305	19,127	17
18	30	Depreciation	Actual			941,974			200,098	18
19	32	Interest	Square Feet	234,706		1,640,054		64,305	449,344	19
20	35	Equipment Rental	Revenue	8,216,819		53,719		4,135,295	27,035	20
21	39	Ancillary		1		469,177		1	469,177	21
22	42	Provider Participation Fee		1		51,057		1	51,057	22
23	43	Independent Living/Marketing		1		1,217,802	673,305	0	0	23
24	12	Social Service	Revenue	8,216,819		486		4,135,295	245	24
25	TOTALS					$ 6,989,292	$ 673,305		$ 2,708,754	25

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank of Scotland		X	Mortgage Interest	interest only	3/31/94	$ 25,605,000	$ 24,770,814			$ 1,650,388	1
2												2
3												3
4												4
5												5
	Working Capital											
6				Operating Interest							248	6
7												7
8												8
9	TOTAL Facility Related						$ 25,605,000	$ 24,770,814			$ 1,650,636	9
	B. Non-Facility Related*											
10	Supplemental Schedule											10
11	Interest Income										(10,582)	11
12	Alloc. To Independent Living										(1,190,712)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,201,294)	14
15	TOTALS (line 9+line14)						$ 25,605,000	$ 24,770,814			$ 449,342	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 64,305 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Montgomery Place Retirement Community: 170,401 SQ FT; 165 UNITS

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	13,650	1990	$ 653,213	1
2					2
3	TOTALS	13,650		$ 653,213	3

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1992	1992	$ 4,202,732	$ 140,091	30	$ 140,091	$	$ 1,191,953	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1993	5,903						9
10	Building Improvements			1993	21,460						10
11	Building Improvements: Carpet (Jan - June)			1994	2,095						11
12	Building Improvements: (Jan - June)			1994	672						12
13	Land Improvements: Fence (Jan - June)			1994	1,024						13
14	Building Improvements: (July - Dec)			1994	11,769						14
15	Building Improvements: Carpet (July - Dec)			1994	2,902						15
16	Building Improvements: (Jan - June)			1995	16,265						16
17	Building Improvements: Carpet (Jan - June)			1995	2,172						17
18	Building Improvements: Floor Tiles (July - Dec)			1995	862						18
19	Building Improvements: Carpet (July - Dec)			1995	354						19
20	Building Improvements: Carpet (July - Dec)			1995	1,164						20
21	Building Improvements: Carpet (July - Dec)			1995	101						21
22	Building Improvements: Carpet (July - Dec)			1995	1,427						22
23	Building Improvements: Painting & Decorating (July-Dec)			1995	1,365						23
24	Building Improvements: Carpet (Jan - June)			1996	600						24
25	Building Improvements: Carpet (Jan - June)			1996	795						25
26											26
27	Total Depreciation on all Improvements					16,689		16,689		46,258	27
28											28
29											29
30											30
31	Page 12A				112,460						31
32	Page 12B				39,009						32
33	Page 12C				28,543						33
34	Page 12D										34
35											35
36	TOTAL (lines 4 thru 35)				$ 4,453,674	$ 156,780		$ 156,780	$	$ 1,238,211	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements: Elevator Repairs (Jan - June)			1996	681						9
10	Building Improvements: Window Blinds (Jan - June)			1996	407						10
11	Building Improvements: Carpet (July - Dec)			1996	2,475						11
12	Building Improvements: Carpet (Jan - June)			1997	4,058						12
13	Building Improvements: Outdoor Lighting (Jan - June)			1997	291						13
14	Building Improvements: Elevators			1998	51,767						14
15	Building Improvements: Electrical / Security			1998	8,989						15
16	Sprinkler System			Aug-98	1,525						16
17	Access Panels			Aug-98	1,825						17
18	Fire Dampers			Sep-98	3,884						18
19	10 Fire Dampers			Mar-99	2,036						19
20	Recovers for Window Awnings			Nov-98	1,526						20
21	Upper Cabinets			Apr-99	215						21
22	Renovations 2nd &3rd Floor Walls			May-99	11,600						22
23	Start-up of Chiller Units			Jun-99	149						23
24	Sensors & Valves / Connetors			Jun-99	862						24
25	House Pump Bearing Assemble			Jun-99	1,032						25
26	Chilled Water Pump			Jun-99	307						26
27	A/C Compressor Repairs & Suction			Jun-99	2,696						27
28	Kitchen Hot Water System Repairs			Jun-99	557						28
29	2nd Draw on 2nd & 3rd Floor Renovations			Jun-99	11,600						29
30	Cleaned Dri-Steam Humidifiers			Jun-99	502						30
31	Paint Supplies			Jun-99	737						31
32	Repair to Canopy Structure			Jun-99	178						32
33	Inoperative Pison Assembly			Jun-99	980						33
34	Recovers for Window Awnings			Jun-99	1,526						34
35	Air Filters on Air Handler Units			Jun-99	55						35
36	TOTAL (lines 4 thru 35)				$ 112,460	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Vac System & Air Damper			Jun-99	1,069						9
10	Upper Cabinets			Jun-99	215						10
11	Steel Overhead Door			Aug-98	645						11
12	Elevator - Panaforty Detector			Jun-00	603						12
13	Kitchen Grease Exhaust			Dec-99	414						13
14	Nurse Call System			Nov-99	763						14
15	HVAC Coils			Jul-99	2,350						15
16	Pneumatic Controls			Jul-99	1,491						16
17	Roof Duct Insulation			Jul-99	2,916						17
18	Motor			Jul-99	544						18
19	A/C Valves			Jul-99	1,275						19
20	Risers			Nov-99	419						20
21	Fire Dampers			Nov-99	9,396						21
22	Drywall / Firestop			Feb-00	897						22
23	Replace Front Step			Sep-99	411						23
24	Shower Water Valves			Aug-99	437						24
25	Landscaping (not in 6/99 GL; not in 6/99 cost report)			Jun-99	1,062						25
26	Corridor Walls (not in 6/99 GL; not in 6/99 cost report)			Jun-99	3,178						26
27	Doors & Frames			Jul-99	2,625						27
28	Life Safety Code Review			Nov-99	679						28
29	Damper Drawings			Nov-99	683						29
30	Damper Drawings			Nov-99	730						30
31	Gutters & Drains			Dec-99	2,534						31
32	Light Covers			Mar-00	2,622						32
33	Faucet & Door Closer			Aug-99	190						33
34	Push Button Locks			Apr-00	683						34
35	Doors			Jun-00	178						35
36	TOTAL (lines 4 thru 35)				$ 39,009	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Door & Frames			May-00	938						9
10	Air Handling Unit			Apr-00	4,630						10
11	Boiler Overhaul			May-00	1,184						11
12	Freezer Fan Motor			Apr-00	441						12
13	Kitchen Floor			Apr-00	9,551						13
14	Wallpaper & Paint			Jul-99	2,906						14
15	Paint			Dec-99	2,946						15
16	Window Treatments			Nov-99	453						16
17	Awnings			Apr-00	382						17
18	Garden Sprinkler Repair			May-00	1,151						18
19	Stainless Steel Wall Covering			Jun-00	3,961						19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 28,543	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 303,729	$ 29,654	$ 29,654	$		$ 182,889	37
38	Current Year Purchases	98,181	13,182	13,182			13,182	38
39	Fully Depreciated Assets	8,807					8,807	39
40								40
41	TOTALS	$ 410,717	$ 42,836	$ 42,836	$		$ 204,878	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility	1999 Ford Windstar Van	2000	$ 4,821	$ 482	$ 482	$	5	$ 482	42
43										43
44										44
45										45
46	TOTALS			$ 4,821	$ 482	$ 482	$		$ 482	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 5,522,425	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 200,098	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 200,098	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,443,571	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Allocation to Independent Living	$ 21,034,889	$ 742,003	$ 5,638,768	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 21,034,889	$ 742,003	$ 5,638,768	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Montgomery Place
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
6/30/00

LINE 28: PRIOR YEARS

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
Montgomery Place	303,729	29,654	29,654		182,889
TOTALS	303,729	29,654	29,654		182,889

LINE 29: CURRENT YEAR

Montgomery Place	98,181	13,182	13,182		13,182
TOTALS	98,181	13,182	13,182		13,182

LINE 30: FULLY DEPRECIATED

Montgomery Place	8,807				8,807
TOTALS	8,807				8,807

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		93		$			3
4	Additions							4
5								5
6								6
7	TOTAL		93		$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 14,279 Description: SEE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Bus Rental		$	$ 1,742	17
18	Resident Transport	Ford F350 Terra Transit	952.51	11,018	18
19					19
20					20
21	TOTAL		$ 952.51	$ 12,760	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 47,113	$		$ 47,113	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,133			2,133	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			111,982			111,982	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				174,412		174,412	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39-3, 39-2				75,116	58,421		133,537	13
14	TOTAL			$ 0		$ 236,344	$ 232,833		$ 469,177	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	34,739
2	Complex Medical Equip	4,163
3	Oxygen	210
4	Equipment Rental	19,309
5		
6		
7		
8		
9		
10		
		58,421

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	75,116
2		
3		
4		
5		
6		
7		
8		
9		
10		
		75,116

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,031,788	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	581,501		3
4	Supply Inventory (priced at)	11,626		4
5	Short-Term Investments			5
6	Prepaid Insurance	4,054		6
7	Other Prepaid Expenses	14,703		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,643,672	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	3,253,612		13
14	Buildings, at Historical Cost	21,357,997		14
15	Leasehold Improvements, at Historical Cos	412,990		15
16	Equipment, at Historical Cost	1,530,782		16
17	Accumulated Depreciation (book methods)	(7,082,213)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 19,473,168	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 21,116,840	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,815,578	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	123,308		30
31	Accrued Taxes Payable (excluding real estate taxes)	41,616		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,888,449		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	685,522		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,554,473	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	24,770,814		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 24,770,814	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 31,325,287	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (10,208,447)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 21,116,840	$	48

***(See instructions.)**

Facility Name & ID Number Montgomery Place **#** 0037515 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 6/30/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow		

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses	237,602	
Accrued R. E. Tax - Non Care Property		
Security Deposits	441,538	
Refunds Due	(1,119)	
Resident Trust Fund Liability	1,079	
Other Payroll Withholdings	6,422	
	685,522	

OTHER NON CURRENT ASSETS:		
Construction In Progress		
Utility Deposit		
Loan Costs		

OTHER NON CURRENT LIABILITIES:		

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (8,631,062)	1	
2	Restatements (describe):		2	
3	**Schedule attached**	(509,357)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (9,140,419)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,068,028)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,068,028)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (10,208,447)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number	Montgomery Place	#	0037515	Report Period Beginning:	7/1/99	Ending:	**6/30/00**

Balance per General Ledger		(9,140,419)
Adjustments:		
		-
Change in FS after 6/30/99 cost report preparation:		
Cash Operating Account		(5,348)
Allowance for Doubtful Accounts		400,000
A/R - HC - Private Pay		100,866
Due to / from Medicare (1997)		26,447
Due to / from Church Home		(56,418)
A/P Trade		22,261
Employee Federal Tax W/H		9,605
Accrued Expenses		11,944
Total adjustments		509,357
Balance - Beginning of Year		(8,631,062)
Equity(Deficit) from Page 17 Col 1		(10,208,447)
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		(10,208,447)

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,121,625	1
2	Discounts and Allowances for all Levels	(417,222)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,704,403	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	491,289	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 491,289	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	79,231	14
15	Telephone, Television and Radio	38,445	15
16	Rental of Facility Space	206,712	16
17	Sale of Drugs	169,465	17
18	Sale of Supplies to Non-Patients	6	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	144,812	21
22	Laundry	17,166	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 655,837	23
	D. Non-Operating Revenue		
24	Contributions	(15)	24
25	Interest and Other Investment Income***	10,583	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10,568	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	4,171,702	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,171,702	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,033,799	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,805,546	31
32	Health Care	1,607,454	32
33	General Administration	2,304,462	33
	B. Capital Expense		
34	Ownership	2,646,329	34
	C. Ancillary Expense		
35	Special Cost Centers	1,686,979	35
36	Provider Participation Fee	51,057	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,101,827	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,068,028)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,068,028)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Montgomery Place # 0037515 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

SUPPLEMENTAL SCHEDULE OF REVENUES
6/30/00

	DESCRIPTION		AMOUNT
1	Independent Living Monthly Fees		4,081,525
2	Activities Services Revenue		6,252
3	Care Management Services		35,022
4	Contract Services Revenue		1,015
5	Housekeeping Services Revenue		1,177
6	Maintenance Services Revenue		6,292
7	Miscellaneous Services Revenue	(adjusted out on page 5)	5,393
8	Personal Care Services Revenue	(adjusted out on page 5)	9,172
9	Third Party Special Event Revenue		387
10	Transportation Revenue	(adjusted out on page 5)	6,648
11	Tray Service Revenue	(adjusted out on page 5)	(5)
12	Vending Revenue	(adjusted out on page 5)	44
13	Administrative Fees		230
14			
15	Management Fees - Church Home	(adjusted out on page 5)	18,000
16	Gain on Disposal of Assets		550
		TOTALS	4,171,702

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,596	2,952	$ 73,971	$ 25.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	25,016	27,220	456,782	16.78	3
4	Licensed Practical Nurses	10,068	10,687	158,147	14.80	4
5	Nurse Aides & Orderlies	72,652	77,723	484,538	6.23	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,151	3,406	45,207	13.27	9
10	Activity Assistants	6,908	7,572	44,687	5.90	10
11	Social Service Workers	2,126	2,296	37,954	16.53	11
12	Dietician					12
13	Food Service Supervisor	5,310	5,738	84,546	14.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	39,592	42,061	299,972	7.13	15
16	Dishwashers					16
17	Maintenance Workers	11,241	12,066	144,702	11.99	17
18	Housekeepers	19,976	21,107	144,020	6.82	18
19	Laundry	6,016	6,602	43,353	6.57	19
20	Administrator	1,071	1,077	40,375	37.49	20
21	Assistant Administrator					21
22	Other Administrative	447	455	19,300	42.42	22
23	Office Manager					23
24	Clerical	7,053	7,510	151,445	20.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,701	4,017	56,371	14.03	31
32	Other Health Care(specify)					32
33	Other(specify)	2,292	2,432	15,736	6.47	33
34	TOTAL (lines 1 - 33)	219,216	234,921	$ 2,301,106 *	$ 9.80	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	17	$ 834	1-3	35
36	Medical Director	Monthly	13,701	9-3	36
37	Medical Records Consultant	Monthly	2,376	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	613	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychosocial	10	486	12-3	47
48	Dietary Contract Labor		21,653	1-3	48
49	TOTAL (lines 35 - 48)	39	$ 39,663		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	29	$ 1,432	10-3	50
51	Licensed Practical Nurses	354	10,325	10-3	51
52	Nurse Aides	370	7,367	10-3	52
53	TOTAL (lines 50 - 52)	753	$ 19,124		53

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Transportation	2,292	2,432	$ 15,736	$ 6.47
	2,292	2,432	$ 15,736	$ 6.47

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Apa	Executive Director	0	$ 38,349
Kevin Ahmadi	Administrator	0	80,225
Less:			
allocation to Independent Living			(58,899)
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 59,675

B. Administrative - Other

Description	Amount
Greystone Management Services	$ 18,839
TOTAL (agree to Schedule V, line 17, col. 3)	$ 18,839
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
KPMG Peat Marwick	Accounting	32,180
Personnel Planners	Unemployment Consult	384
ADP Total Tax Plus	Unemployment Consult	1,504
Healthcare Directions	Billing / Receivable Cons.	22,456
FR&R	Medicare/Medicaid Consult.	47,123
ADP	Payroll Processing	21,527
various - see attached	Computer Consultant	47,235
various - see attached	Legal	159,870
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 332,279

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 64,587
Unemployment Compensation Insurance	62,620
FICA Taxes	216,134
Employee Health Insurance	
Employee Meals	24,376
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	38,610
Employee Evaluations - drug testing	3,166
Employee 403B Contribution	287
Employee Relations	5,028
Less: Allocation to Independent Living	(94,108)
TOTAL (agree to Schedule V, line 22, col.8)	$ 320,700

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	74,727
Health Care Worker Background Check	2,794
(Indicate # of checks performed 212)	
Dues & Subscriptions	11,056
Licenses, Permits & Fees	3,681
Less: Allocation to Independent Living	(45,827)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,431

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	10,467
Less: Undocumented Seminar Exp.	(1,475)
Less: Allocation to Independent Living	(4,467)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,525

**See instructions.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/99 Ending: 6/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Life Services Network $6843

(3) Did the nursing home make political contributions or payments to a politica action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 25,231 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ 51,057
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ 24,376 Has any meal income been offset against related costs? YES Indicate the amount. $ 54,377

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln. 1
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: KPMG PEAT MARWICK LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. NOT COMPLETE

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw